Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2620AGC	A. BUILDING _____ B. WING _____	03/19/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN VALLEY ELDERCARE	2961 E SERENE AVE HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 3/19/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for 8 Residential Facility for Group beds for elderly and disabled person and/or persons with mental illness. The census at the time of the survey was 6. Six resident files were reviewed and 4 employee files were reviewed. The following deficiencies were identified:	Y 000		
Y 070 SS=F	449.196(1)(f) Qualifications of Caregiver-8 hours training NAC 449.196 1. A caregiver of a residential facility must: (f) Receive annually not less than 8 hours of training related to providing for the needs of the residents of a residential facility. This Regulation is not met as evidenced by: Based on record review on 3/19/09, the facility failed to ensure 2 of 4 caregivers received eight hours of annual training (Employee #2 and #3). Severity: 2 Scope: 3	Y 070		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE ADMINISTRATOR — (X6) DATE 4/1/09

Green Valley Elder Care

2961 East Serene Avenue, Henderson, NV 89074
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Fax No (702) 974 2004, Email gmargaroli@aol.com

April 1, 2009

Acceptable POC
4/14/09
D Seeger RN

Ms. Debra L. Seeger, RN
Health Facilities Surveyor II
State of Nevada
Department of Health and Human Services
Bureau of Health Care Quality & Compliance
4220 South Maryland Parkway
Suite 810, Building D
Las Vegas, NV 89119

Re: Statement of Deficiencies and Plan of Correction

Dear Ms. Seeger,

Please find herewith our Plan of Correction as a result of the survey conducted in our facility on 3/19/2009. We have placed or Plan of Correction in this form as we still have not found a way to reply readable on the original form.

Y 070 449.196 (1) (f)

A) Employee #2 and #3 have been enrolled in an 8 hour Medication Management Training on March 21, 2009
B) All employee files will be reviewed every 6 months to ensure employees have enough training based on the annual / license requirements. A Personnel file checklist (Attachment #1) will be utilized to determine if training is needed. Employees will be enrolled in annual classes prior to expiration dates. The administrator will monitor for compliance. Employee #2 & #3 have completed the 8 hour training as per Attachment #2
C) 3/21/2009

Y 106 449.200 (2) (a)

A) Employee #3 has been enrolled in a CPR/First Aid class with Medic One to be held on 3/28/2009.
B) All employee files will be reviewed every 6 months to ensure employees have current First Aid/CPR cards. A Personnel file checklist (Attachment #1A) will be utilized to determine if training is needed. Employees will be enrolled in re-certification classes prior to expiration dates. The administrator will monitor for compliance.
Employee #3 has completed the CPR/First Aid certification on 3/28/2009 as per attachment #3.
C) 03/28/2009

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Y 859 449.274 (5)

A) All residents will be reviewed by their individual Physician annually

B) All residents will be reviewed annually by their individual physician. A package designed by the group home (attachment # 4) containing "checklist admission papers, Standard Physician Assessment, Physician Statement for Resident to remain in a Group Home, Standard Placement Determination, General Physical Exam/Systems Review and Two Step "Mantoux Tuberculin Test" will be used for the annual assessment. The annual assessment will be done prior to expiration date of Mantoux Test or annual anniversary of the resident. If the Group Home Management, Caregiver, Health Care Professional or Relative feels that a higher level of care might be needed an assessment will be initiated. If the results of the assessment indicate that a higher level of care is required the administrator will, in close coordination with the client and/or the client's responsible party (P.O.A., legal guardian etc.) assist the client in finding a placement in the level of care the client should be based on the assessment of the medically trained professional/physician.
The administrator will monitor for compliance.

C) 03/23/2009

Y 870 449.2742 (1) (a) (1) (2) (b) (c) 449.2742 (1) (a) (1)

A) All medication reviews will be done twice a year.

B) All medication reviews for each individual resident will be done twice a year or every month of March and September of each year. In principle the group home will request the contracted pharmacy to review the medications. A request for medication review was send to One Priority Pharmacy on 3/24/2009 for Resident #1, #2, #3, #4 and #6. (Attachment #5). The administrator will monitor for compliance.

C) 03/24/2009

Thank you.

Giovanni F. Margaroli

"The home you can trust to sincerely love and care for you and the ones you love....."